STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155710	A. BUILDING 01 B. WING	03/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHASE CENTER	2 CHASE PARK LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/20/14 Facility Number: 000021 Provider Number: 155710 AIM Number: 100275270 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Chase Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated detectors in all	K010000	Chase Center (the Provider) submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. The submission of the PoC does not indicate an admission by Chase Center that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Chase Center. This PoC shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is submitted as a matter of statute only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	resident sleeping rooms. The facility has a capacity of 101 and had a census of 71 at the time of this survey. All areas where residents have customary access were sprinklered. All areas which provided facility services were sprinklered except the two detached buildings which include a generator housed in a wood frame building and a wood frame laundry building. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/31/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 doors leading to hazardous areas in the basement such as rooms with stored combustible items was provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 26 residents on first floor above the basement as well as visitors and staff. Findings include: Based on observation on 03/20/14 at 2:22 p.m. with the Maintenance Supervisor, the Activities storage room on 400 hall in the basement contained forty eight cardboard boxes inside the room which was greater than fifty square feet in size and did not have a self closing device on the corridor door. Based on interview on 03/20/14 at 2:28 p.m. with the	K010029	1. Corrective Action - The old closure was not working and a new closure had been ordered. A new closure was re-installed on the storage room door.2. This door will be checked weekly during the facility's inspection for Life Safety compliance (see exhibit A)3. The inspection results will be reported monthly to the facility's QA Committee.4. The Maintenance Director is responsible to monitor compliance5. The closure was installed on the storage door 3/24/2014.	03/24/2014

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	Maintenance Supervisor, it was acknowledged the aforementioned door leading into the Activities storage room containing combustible items was not equipped with a self closing device on the door. 3.1-19(b)			

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K010038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure exit access was arranged so 1 of 12 exits were readily accessible at all times. LSC Section 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock requiring the use of a tool or key from the egress side. Exception No. 1 Door locking arrangements without delayed egress shall be permitted in health care occupancies provided staff can readily unlock such doors at all times. LSC Section 7.1.10.1 requires means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect any resident as well as visitors and staff using the smoking hut. Findings include: Based on observation on 03/20/14 at 1:25 p.m. with the Maintenance Supervisor, Exception No. 1 was not met: the exit door out of the smoking hut adjacent to Dietary was equipped with a magnetic lock on the door which could not be deactivated without activating the fire	K010038	1. Corrective Action: The 15 second delay for the exit door to the smoking hut was instaffed on 3/26/2014. A keypad with the code will be installed on 4/14/2014. Staff will be inserviced on the location of the keypad and code by 4/14/2014.2. This facility conducts weekly Life Safety Compliance inspections, and the Exterior Exit Door to the smoke hut has been added to the life safety worksheet. (Refer to Exhibit B)3. Monthly maintenance reports are provided to the QA Committee, and the report will include checks of the exit doors with keypad codes.4. The Maintenance Director is responsible for monitoring compliance.5. The final correction date is 4/14/2014.	04/14/2014

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	alarm. The exit door would not release in fifteen seconds and there was no keypad or staff key which would release the magnetic hold on the door. Based on interview on 03/20/14 concurrent with the observation with the Maintenance Supervisor it was acknowledged the electromagnetic lock on the smoking hut exit door could not be opened any other way except for the fire alarm system to be activated. 3.1-19(b)			